Grace Chiropractic Center, Inc. 309 West Main St. Cabot, AR
501-941-3008

New Patient Form

Date_____

Who may we thank for referring you?_____

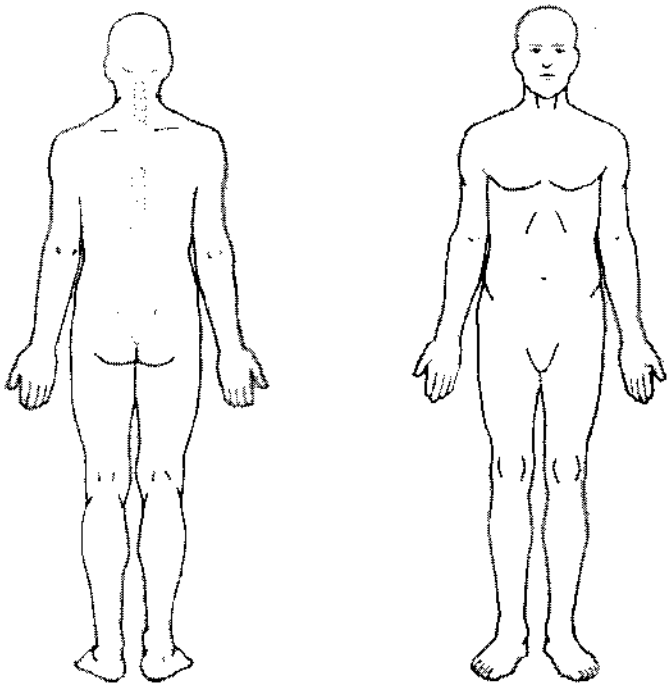
Patient Name_____ Address_____ City_____ State___ Zip_____
Home Ph _____ Work Ph_____ Birth Date_____ Age____
Social Security #_____-____-_____ Sex □ Male □ Female Married □ Yes □ NO
List Children/Age_____
Employer/Work Address_____
Emergency contact or Spouse Name_____ Spouse's Employer_____Ph_____
Is this injury a result of: □ Auto accident □ Personal injury □ Other:_____
Have you been in a recent accident? □ YES □ NO If yes please explain:_____
_____
_____
Have you seen other doctors for this condition? □ YES □ NO Who_____Did it help? □ Yes □ NO
Are you now or have you even been disabled/ Impaired? □YES □ NO If yes how? _____

Chief Complaint/ Spinal regions of pain When did your complaint BEGIN _____

Explain why you are here today_____
_____
_____
_____

Severity of Pain
Circle the severity of your condition for each area listed
1= least 10= Greatest

Place these marks on the area of complaint
+ Burning X Sharp * Ache 0 Stabbing • Numbness ▲ Tingling



Left **Right**

Please mark areas(s) of pain on
The drawing on the left.

Neck _____
1 2 3 4 5 6 7 8 9 10

Mid Back_____
1 2 3 4 5 6 7 8 9 10

Low Back_____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10

How does your present condition affect you while performing these activities? Check one box for each activity.

Bending……...□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Change position				
Sitting to standing…...□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Computer use……..□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Climbing stairs……□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Driving……□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Lifting…….□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Reading…….....□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Self care				
Bathing,dressing …..□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Sexual activities……□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Sitting, walking				
Standing……□	No Effect	□ Mild painful, can do	□ Moderate painful, limited ability	□ Severe unable to perform
Sleeping……□	No Effect	□ unable to rest all night	□ Difficult to go to sleep	□ Unable to sleep at all

List other activities affected:

_____ □ Mild painful, can do □ Moderate painful, limited ability □ Severe unable to perform

Family History

Mother - Living □ Yes □ No Cause of death_____

Father - Living □ Yes □ No Cause of death_____

Brothers - # of ____

Sisters - # of ____

Have you had any of the following diseases? Check all that apply

□ Alcoholism □ Anemia □ Appendicitis □ Arthritis □ Cancer □ Diabetes □ Eczema □ Epilepsy □ Goiter
□ Heart Disease □ HIV positive □ Low Back Pain □ Measles □ Mental Disorder □ Pleurisy □ Pneumonia
□ Scoliosis □ Sprain/Strain Sacroiliac □ Whiplash □ Vision problems □ Blood Thinners
□ Ears, Nose or Throat problems: Explain_____ □ Respiration problems Explain_____
□ Cardiovascular problems Explain_____
□ Headaches □ Skin issues_____ □ Dizziness □ Depression □ Allergies_____
□ Auto accidents what year_____ □ Blood clotting problems □ Hearing problems □ Loss of sleep
□ Numbness □ Strokes □ Heart attacks

Has your current complaint ever occurred before? □ Yes □ NO When? _____

List any dislocations or any broken bones_____

Have you ever been unconscious? _____

Have you ever had x-rays taken? _____

List any hospital stays within the last two years and why._____

Please list all surgical procedures you have EVER had and their dates_____

Do you suffer from any condition other than that for which you are now consulting us?_____

Please list all prescriptions and over the counter medications you are CURRENTLY taking. _____

_____

_____

List all health conditions not previously specified adult and childhood_____

Are you pregnant? □ Yes □ NO Tobacco use: □ none ___ per □ Day □ Week □ Month

Alcohol □ None ___# per □ Day □ Week □ Month

Health Care Privacy Notice/ Assignment of Benefits

This office is committed to providing patients with quality healthcare services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff. This facility is required by law to abide by the terms of this health care privacy notice as well as other applicable federal and state laws governing privacy practices in health care. Our facility may change and or modify the terms of this notice at anytime without additional notice to you except to publicly post in our facility and or make available to patients and updated notices. Photocopy of this notice is available upon request. The facility refers to this office or clinic. The term Provider refers to doctors and or licensed professionals of this facility.

Our facility and staff are committed to maintaining the privacy of your protected health information(PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future, and past mental health or condition and the care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this notice and direct questions, misunderstandings or concern to the compliance officer of this facility.

Our facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and or disclosed without your written authorization by the doctors and staff of this facility for the purposes of your care and treatment, paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The privacy rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing will be in compliance with state law. Your provider will comply with any reasonable request to have confidential communication by alternative means or by an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization in writing at any time, except in the event that the provider has acted as indicated in the doctor's authorization notice.

You have the right to file a written complaint with our compliance officer if you believe that any of your privacy rights have been violated. You can obtain a compliant form from the compliance officer if you believe that any of your privacy rights have been violated. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The privacy law prohibits our facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated, comprehensive health care privacy notice is available for your review in this facility.

I understand that this facility, it's doctors and staff are accepting my case based on examination finding and believe the outlined treatment should produce change and or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy and physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains strains, drug interactions and reactions and other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedures which the doctor/provider feels at the time is in my best interest.

In addition, because psycho social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment but must be aware of the probable consequences of refusing treatment and or failing to cooperate with the prescribed treatment. Should you refuse and or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this facility.

I, the assignee agrees that this facility and staff may deliver medical records, consultations, depositions and or court appearances which must be paid in full in advance and authorizes this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse and or sign my name on any and all checks for payment of any indebtedness owed this office and assignee.

Print Patient Name:_____ Sign Patient Name:_____ Date:_____